

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 02-18-05.

The IRO reviewed therapeutic activities, therapeutic exercises and neuromuscular re-education rendered from 05-07-04 through 08-18-04 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 03-08-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97530 (52 units)(26 DOS) dates of service 02-16-04, 02-18-04, 02-20-04, 02-23-04, 02-25-04, 02-27-04, 03-01-04, 03-03-04, 03-08-04, 03-10-04, 03-12-04, 03-15-04, 03-17-04, 03-24-04, 04-02-04, 04-05-04, 04-07-04, 04-09-04, 04-12-04, 04-14-04, 04-26-04, 04-28-04, 04-30-04 and 05-03-04 denied with denial code "O/YO" (reimbursement was reduced or denied after reconsideration of treatment/service billed). Original EOBs were not submitted by either party. Since neither party submitted original EOBs the review will be per Rule 134.202. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$1,934.92 (\$29.77 X 125% = \$37.21 X 52 units).**

CPT code 97110 (26 units)(26 DOS) dates of service 02-16-04, 02-18-04, 02-20-04, 02-23-04, 02-25-04, 02-27-04, 03-01-04, 03-03-04, 03-08-04, 03-10-04, 03-12-04, 03-15-04, 03-17-04, 03-24-04, 04-02-04, 04-05-04, 04-07-04, 04-09-04, 04-12-04, 04-14-04, 04-26-04, 04-28-04, 04-30-04 and 05-03-04 denied with denial code "O/YO" (reimbursement was reduced or denied after reconsideration of treatment/service billed). Original EOBs were not submitted by either party. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what

constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. Reimbursement not recommended.

CPT code 97112 (26 units)(26 DOS) dates of service 02-16-04, 02-18-04, 02-20-04, 02-23-04, 02-25-04, 02-27-04, 03-01-04, 03-03-04, 03-08-04, 03-10-04, 03-12-04, 03-15-04, 03-17-04, 03-24-04, 04-02-04, 04-05-04, 04-07-04, 04-09-04, 04-12-04, 04-14-04, 04-26-04, 04-28-04, 04-30-04 and 05-03-04 denied with denial code "O/YO" (reimbursement was reduced or denied after reconsideration of treatment/service billed). Original EOBs were not submitted by either party. Since neither party submitted original EOBs the review will be per Rule 134.202. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$955.50 (\$29.40 X 12% = \$36.75 X 26 units).**

This Findings and Decision is hereby issued this 19th day of May 2005.

Medical Dispute Resolution Officer  
Medical Review Division

### **ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees for dates of service 02-16-04 through 05-03-04 totaling \$2,890.42 in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is hereby issued this 19th day of May 2005.

Medical Necessity Team Manager  
Medical Review Division

Enclosure: IRO decision

**Envoy Medical Systems, LP**  
**1726 Cricket Hollow**  
**Austin, Texas 78758**

**Phone 512/248-9020**

**Fax 512/491-5145**

**IRO Certificate #4599**

## NOTICE OF INDEPENDENT REVIEW DECISION

May 17, 2005

**Re: IRO Case # M5-05-1733 –01**

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

### Medical Information Reviewed

1. Table of disputed services
2. Denial letters
3. Medical records, 10/03 – 9/04 Dr. Esses
4. Evaluation, 7/19/04, Dr. Evans
5. MRI lumbar spine report 4/8/03
6. Operative report 8/21/03
7. Consultation note, 8/12/04, Dr. Shanti
8. EMG/NCS report 7/8/02
9. Physical therapy treatment records ¼ - 7/04

History

The patient is a 30-year-old male who injured his back in \_\_\_\_ when he was lifting a box of material on to a shelf when the box fell back on him. This led to a two-level fusion at L4-5 and L5-S1 on 10/8/03. On 2/12/04 the patient was cleared by his surgeon to begin physical therapy.

Requested Service(s)

Therapeutic activities, therapeutic exercises, neuromuscular reeducation 5/7/04 – 8/18/04

Decision

I agree with the carrier's decision to deny the requested physical therapy services.

Rationale

The patient had been cleared by his surgeon to begin physical therapy on 2/12/04. The notes provided for this review do not indicate why the patient needed to continue physical therapy beyond three months after beginning his rehabilitation program. No documentation was provided of the patient's response to therapy or of the need for continuation of therapy beyond 8-12 weeks. The patient should have been transitioned to a home exercise program and discharged.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

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Daniel Y. Chin, for GP